

Medical Information Release Form
(HIPPA Release Form)

Name: _____ Date of Birth: ___/___/___

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse _____

Child(ren) _____

 Other _____

Information is not to be released to anyone.

Signature: _____ Date: _____